SOME MORAL ISSUES CONCERNING CURRENT WAYS OF DEALING WITH SURGICAL PATIENTS*

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IT is now well known that surgical residents participate extensively in surgery performed on private patients. Their participation is extensive, both in number of operations in which they are involved and their role in any given operation. This involvement of the surgical resident raises a number of moral questions. Among them are questions as to what to tell the patient about who is doing the surgery, the risk to the patient when the resident performs the surgery, and the fee appropriate for the surgeon to charge when the resident is the primary operating surgeon. In this paper I am going to concentrate on the first question, though I shall have things to say about the last question as well. I shall be talking about surgery performed on private patients, not ward or service patients, though what will be said has implications for these patients also.

Interviews I have conducted with residents and attending physicians in several hospitals in New York City and the Lifflander Report on "ghost surgery"† suggest that surgical patients are currently dealt with as follows. Patients are not directly and unequivocally told by their surgeons that a surgical resident (a surgeon-in-training) will participate, or participate extensively, in their operation. Instead, they are told that modern surgery is a team effort, that a team of surgeons will be involved, and that the surgeon they engaged will be the "responsible" surgeon. This does not change the belief of the patient that the surgeon engaged will perform, if not the entire operation, then at least the major or most serious part of it. In fact, in many instances, the chosen surgeon does very little or none of

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the surgery, but is involved rather in a supervisory and back-up capacity.

Thus, the patient does not get what he was led to believe he would get, the operative service of the surgeon he engaged. Further, although the patient's operation is performed by the resident, in many instances he is charged the surgeon's customary fee, the fee the surgeon does or would charge were he the primary operating surgeon.

This picture contains at least five elements that are open to criticism on moral grounds. The first questionable element concerns what patients are told about who will be involved in their operation. The main problem with the surgeon telling his patient that the surgery will be performed by a team is that it masks both the actual reason why residents operate and the true role of the surgeon in the operating room. Calling surgery a team effort makes it sound as if a group of already trained and experienced surgeons will operate. And, whereas a team approach is undoubtedly required for certain operations, the team concept, according to the Lifflander Report, is invoked for such procedures as herniorrhaphies, appendectomies, hysterectomies, colectomies, and cholecystectomies. It is disingenuous to say that such operations require a team approach. Moreover, even if it is granted that a team approach for these operations is in some sense better than a nonteam approach, to tell the patient that his operation is a team effort still masks the fact that the resident is on the team principally because he is in training, that he is trying to learn or to get better at the procedure in question. It still masks the fact that the surgeon's principal involvement with the operation is in a supervisory and back-up capacity. The patient, however, has the right to know the true roles of both resident and surgeon. This is extremely important information. It is information which could serve as a basis for the patient electing not to undergo the operation or deciding to look for an experienced surgeon to perform the entire operation. It must be remembered that morally the whole point of an informed consent requirement is to protect people from deception or from being misled so that they can form an accurate picture of the alternatives available and of the risks of each alternative. The purpose of providing an accurate picture is not simply to satisfy the patient's curiosity, thereby honoring his right to know. The purpose is to enable him to decide which alternative is the best given his own values and concerns, thereby honoring his right to choose. Indeed, if he is not provided with an accurate picture of the alternatives, in what sense has his autonomy, his right to determine what others should be allowed to do to him, been preserved?

In addition to (1) the deception involved in failing to clearly and unequivocally inform the patient about who participates in the operation and in what capacity, current practice has other morally objectionable elements. There is an implicit understanding (or contract) between the patient and the surgeon he engages, one component of which is that this surgeon will be the operating surgeon. But to substitute the operative services of the resident for those of the surgeon (2) violates this understanding. The patient understood that he would be receiving the surgeon's operative services, but received the operative services of someone else.* Further, the patient can complain that (3) he is being asked to pay for services which, though understood to be forthcoming, were not rendered. In effect, he is being asked to honor his end of the understanding between himself and the surgeon. The patient can also complain that (4) the operative services he received were inferior to those he understood he would get (more on this point below). Finally, the patient can complain that in paying the surgeon his customary fee, (5) he is being overcharged for the services he actually received, namely, those of the resident.

This last point requires some elaboration. Although there are other ways to make this point, I shall put it in terms of market considerations.† Consider what the patient would be willing to pay on the open market if given the opportunity to make a free and informed choice between the services of a surgeon and those of a resident or, to put the point in a slightly different way, if given a free and informed choice between the surgeon's participation as the primary operating surgeon and his participation in a supervisory and back-up capacity. People quite naturally would purchase the operative services of the surgeon if the fee for those services and the fee for the services of the resident were the same. If they were to purchase the services of the resident at all, it would be for a smaller fee than they are willing to pay for the surgeon's operative services. But when patients are charged the surgeon's fee for surgery done primarily by the resident, they are being asked to pay a fee which they would have been unwilling to pay given a free and informed choice. From this perspective one can say that in being charged the surgeon's customary fee patients are charged more for the services of the resident than those services are worth to them. The

*I do not know whether this would constitute breach of contract legally.

†This should not be taken to mean that I am committed to the marketplace as a morally ideal arrangement for the provision of health-care services. In this paper I am not addressing questions of what would be ideal. We already have a marketplace arrangement. Given that this is what we have, I here deal with how it can be made morally better than it is now.

residents' services are less attractive to the patient than the surgeons', in part because what the patient wants is the greater assurance of the desired result, i.e., successful surgery. Part of what a patient pays a more experienced surgeon for is the greater assurance of successful surgery. The patient does not have this when the resident performs the surgery. While the resident may be as successful in all phases of the surgery, he may not be, and the chances of obtaining the desired result are simply better with an experienced surgeon. Here it is not merely a question of what the resident can do, for one might be fortunate enough to get a top-flight resident. The whole idea here is that of proved success. What the person considering an operation wants to purchase is the services of the doctor with a proved track record, thereby maximizing his chances of a successful result.

Three responses are likely to be elicited by the preceding discussion. First, it may be said that residents, or most of them at any rate, are just as skilled as surgeons—if not in some instances better. So the substitution of the resident for the surgeon does not substitute operative services of lesser but comparable quality. Thus, the operative services of a resident are worth as much to the patient as the operative services of an experienced surgeon. Second, it may be said that the surgeon plays a vital role in the operation and it is for this role that he charges the patient. Thus, the surgeon does not charge for services he has not rendered. He renders important supervisory and back-up services, and clearly it is not wrong for him to charge the patient for these services. Finally, it may be said that the current way of informing the patient about who will operate on him is morally justified. Many patients, it is maintained, would refuse surgery if told that their operation were to be performed by a resident, a surgeon-in-training, and that their own surgeon were to act primarily in a supervisory back-up capacity. If this is so, however, then the entire enterprise of training new surgeons would be brought to a halt, a disastrous consequence which would make all of us immeasurably worse off than we are now. The current way of informing the patient, which allows the training program to go forward, providing us with a new generation of very able surgeons, is therefore justified.

Consider the first point, regarding the claim that residents are as good as surgeons. Three points need to be made. First, no one can substantiate the claim that residents are as competent as experienced surgeons until extensive studies are done to compare the performance of supervised residents

with the performance of surgeons in terms of morbidity and mortality.*

Second, it is simply not true that all residents at every stage of training are as good as experienced surgeons. This would deny the relevance of experience in developing competence as a surgeon—a claim contrary to what most surgeons say as well as to common knowledge about the achievement of competence of almost any skill (e.g., piano playing, bicycle riding, etc.). But third, suppose it were demonstrably true that residents are as proficient as experienced surgeons. Then we could say that when an equally good resident substitutes for the surgeon, the patient cannot complain that he has received operative services of a lesser quality. And perhaps we could say that the patient is not being overcharged. But notice that this would answer only (4) and (5) above. We are still left with points (3), (2), and especially (1)—the point that the substitution of a resident for an experienced surgeon has been concealed from the patient. On that point, the comparable quality of the resident and the surgeon serves as no defense at all. There the relevant consideration is what the patient was told or was led to believe he would get. It is the operative services of the surgeon and not those of the resident that the patient wants, and it is those services he was told or led to believe he would get. The deception involved makes it wrong to substitute a resident for a surgeon, even if the resident is equally competent.

Consider the second point, namely, that it is for his supervisory and back-up role that the surgeon charges the patient. Here, too, several things need to be said. First, this is not made clear to the patient. The patient's understanding is that he is to receive the surgeon's operative services and not his supervisory and back-up services,† and it is for the operative services that the patient has agreed to pay. So the surgeon has violated the understanding between himself and his patient.

Second, I do not think it is appropriate to ask any one patient to bear the full cost of the supervisory and back-up role played by the surgeon. That role needs to be filled precisely because of the additional risks created

*Indeed, until such studies are done and their results made available, I do not see how it is possible reliably to inform the patient about the additional risks he confronts when the resident performs the surgery (risks over and above those present even when an experienced surgeon operates). The patient will not be able to form an accurate picture of the alternatives open to him without reliable information about the risks associated with each of those alternatives. But if this is so, then the patient will not be in a position to make an informed choice between those alternatives, and if he is not in a position to make such a choice he cannot give his informed consent to the proposed operation. It would seem to me, therefore, that if the patient's right to give informed consent is to be taken seriously, the profession has a duty to undertake the studies in question.

†This was powerfully illustrated in a segment of one of the television programs in the CBS series entitled "Sixty Minutes."

for the patient by the resident's participation in his surgery. These are risks that the patient need not face because of his own medical condition. They are brought into existence by a social purpose (the training of new surgeons) extraneous to the patient's own medical needs. Someday it will benefit others that this patient agreed, by making himself "teaching material," to assume those additional risks. It will benefit all those future patients who will need the services of the next generation of surgeons. But, now, because this patient is not the only one to benefit from having made himself teaching material, because through this a social purpose is advanced, he alone should not have to bear the burdens which serving that purpose imposes. This implies, in regard to the burden of the expense for the supervisory and back-up role of the surgeon, that it is wrong for the present patient to shoulder the full cost of that role. Though it is appropriate to ask him to pay a part of that cost because he also benefits from that role, he alone should not be required to pay for all of it.

Consider finally the third point, that were patients told with complete candor who is involved in their surgery and in what capacity, the training program could not go forward. This argument might be persuasive if we could be sure that, in the face of the truth, there was absolutely no way to secure the participation of patients in surgical training. But is this so? Patients could be told by the surgeon they have engaged about how things are done at a teaching hospital and the many important advantages of care at a teaching hospital could be explained to them. They might then be told that it is a condition of entering such a hospital that patients allow residents to assume a large role in their care and to participate in their surgery—extensively if need be. People would then face the choice of whether to enter a teaching hospital or a nonteaching hospital. In the latter institution they would be assured the services of the surgeon they have engaged, but would be deprived of the advantages of care available at a teaching hospital. It seems to me that many people would choose to have their operation at a teaching hospital. If this is so, however, patients could be told the truth and training programs could nevertheless go forward.

It should be observed that this solution would avoid the first three morally objectionable elements of current practice noted at the beginning of this paper, but would still leave open the question of the surgeon's reimbursement, not merely the amount of reimbursement, but the way in which the surgeon should be paid for his actual role in the teaching hospital. This would involve such issues as whether the surgeon should be

on salary at the hospital or whether, in light of the fact that surgical patients are a captive audience in no real position to negotiate, it is the hospital that should control the surgeon's fee. (This point was suggested to me by Professor Herman Somers.)

One final point: a situation similar to the one described in this paper regarding surgery may exist with regard to medicine in some teaching hospitals—a situation that may, to use Dr. Mack Lipkin's phrase, be appropriately described as "ghost medicine." Thus, some physicians have indicated that outside attending physicians are virtually excluded from the essential aspects of medical care for their patients once those patients are admitted to a teaching hospital. The patient then comes under the care of the chief of service and his house staff. Patients, however, are not informed of the situation—of the extensive role of the house staff in their care and of the very minor ancillary role of their own physicians. Nevertheless, the patient's physician, who may make daily visits, does charge his customary fee. With regard to this situation, I would suggest the same solution as the one proposed above.

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